ALTERNATIVE WORK HOURS REQUEST

EFFECTIVE DATE:

Employee Information

Name	Dept / Division	Supervisor

Request Alternative Work Hours

☐ **FLEX Hours** – Five 8 hr/days

Start _____ End _____ / Lunch _____ to _____

☐ **COMPRESSED work weeks**

A: ☐ Four - 10 hr/ days per week Start _____ to _____ / Lunch _____ to _____

B: ☐ Four - 9 hr & One - 4 hr day Start _____ to _____ / Lunch _____ to _____

C: ☐ Wk 1: Four - 9 hr & One - 4 hr day AND Wk 2: Four – 10 hr (one day off every other week)

☐ **ALTERNATIVE WORK WEEK SCHEDULE**

D: ☐ 12 hr. shifts - Alternative Workweek begins SATURDAY @ 11:00
(Dispatchers working 12 hour shifts)

Wk 1: Four - 9 hr & One - 8 hr day AND Wk 2: Four – 9 hr days & one day off

E: ☐ Alternative Workweek begins FRIDAY P.M

F: ☐ Alternative Workweek begins MONDAY P.M

I FULLY UNDERSTAND THAT THE APPROVAL OF ANY WORK ALTERNATIVE IS CONDITIONAL AND MAY BE REVOKED BY MANAGEMENT AT ANY TIME. I HAVE READ THE ALTERNATIVE WORK HOURS POLICY AND FULLY UNDERSTAND THE GUIDELINES SET FORTH. I UNDERSTAND THAT ANY CHANGES TO THIS SCHEDULE WILL NECESSITATE THE COMPLETION OF A NEW FORM.

Employee Signature: _____ **Date:** _____

Required Signatures (Document should be maintained within department)

Supervisor: _____ Date: _____

Dept. Director
or
Division Manager: _____ Date: _____

Supervisor's Comments:

Revised: September 2014